SandsRx Pharmacy

Phone: (844) 598-2557 Fax: (888) 388-1309

Ultomiris (Ravulizumab) Prescriber Order Form

Please Fax completed form with patient's demographics,Clinical notes, and recent labs to (888) 388-1309

PATIENT

Patient Name: _____ Male Female **SS#:** _____ **DOB:** _____

Address: _____ **City, State, Zip:** _____

Primary Phone: _____ | Home Cell Work **Alternate Phone:** _____ Home Cell Work

Email: _____

Clinical Information

Patient Weight: _____ lbs. (required)

Allergies: _____

_____

Diagnosis:
- ☐ Paroxysmal nocturnal hemoglobinuria (PNH) (ICD-10 Code: D59.5)
- ☐ Atypical hemolytic uremic syndrome (aHUS) (ICD-10 Code: D59.3)
- ☐ Myasthenia Gravis w/out acute exacerbation (gMG) (ICD-10 Code: G70.00)

Myasthenia Classification: ☐ II ☐ III ☐ IV

- ☐ Other: _____ (ICD-10 Code: _____)

Ultomiris Prescription Order (Prescriber MUST be enrolled in Ultomiris REMS)

Initial dosing with maintenance (new adult patients):

- ☐ 40kg to 59kg - 2,400mg IV, followed by 3,000mg IV 2 weeks later, then 3,000mg IV every 8 weeks
- ☐ 60kg to 99kg - 2,700mg IV, followed by 3,300mg IV 2 weeks later, then 3,300mg IV every 8 weeks
- ☐ 100kg or > - 3,000mg IV, followed by 3,600mg IV 2 weeks later, then 3,600mg IV every 8 weeks

Maintenance dosing (adult):

- ☐ 40kg to 59kg - 3,000mg IV every 8 weeks
- ☐ 60kg to 99kg - 3,300mg IV every 8 weeks
- ☐ 100kg or greater - 3,600mg IV every 8 weeks

Ancillary Orders

Anaphylaxis Kit If this is a 1st infusion dose, would you like SandsRx Pharmacy to provide an anaphylaxis kit with the 1st dose?
☐ Yes ☐ No

Dosage:
- •Give Diphenhydramine capsule (s) 25 mg to 50 mg PO as needed **#4 capsules**
- •Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SQ or IM x 1; repeat x 1 in 5 to 15 min PRN. **#2 vials**
- •Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg) IV or IM; repeat x 1 in 15 min PRN no improvement. **#1 vial**
- •Normal saline 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis. Patients ≤ 30 kg, infuse over 2 to 4 hours PRN headache rated > 5 on pain scale.

Pre- Medication Orders

- ☐ Acetaminophen 650 mg PO 30 min before infusion, may repeat every 3 to 4 hours as needed for fever or mild discomfort. Patient may decline.
- ☐ Diphenhydramine 25 mg PO 30 min before infusion, may repeat every 4 to 6 hours as needed for mild to moderate allergic reactions. Patient may decline.
- ☐ Loratadine 10 mg PO 30 min before infusion. Patient may decline.
- ☐ Methylprednisolone Succinate _____ mg IV push 20 minutes prior to infusion.
- ☐ Other: _____

IV Flush Orders

- ☐ Peripheral: NS 2 to 3 mL pre-/post-use.
- ☐ Implanted Port: NS 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use. For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed.

Lab Orders

- ☐ No labs ordered at this time.
- ☐ Other: _____

Skilled Nursing Visits: As needed for IV access, administration and appropriate clinical monitoring. Administration procedures to be followed per protocol. Pump and supplies as needed for administration and appropriate disposal of infusion materials. Refill above ancillary orders as directed x 1 year.

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.

Prescriber Signature: **Date:**

Prescriber Information

Prescriber Name:	**Phone:**	**Fax:**
Address:	**NPI:**	
City, State: **Zip:**	**Office Contact:**	